Testimony to the Oregon Senate Committee on Judiciary and Ballot Measure 100 Implementation

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September 21, 2022

Chair Prozanski, Vice-Chair Thatcher, and distinguished committee members, thank you for the opportunity to speak with you today. My name is Keith Humphreys. I am a professor at Stanford University and I served in the White House Office of National Drug Control Policy under Presidents Bush and Obama.

In my remarks today I plan to make just 3 points, which I hope will be of help to you and to the state as you go forward with drug policy reform.

Point 1: Addiction is a legitimate medical disorder, but it's not like, say, sickle cell anemia or chronic pain in two important respects. First, even when it's doing great damage, active addiction to drugs includes intense neurological reward, whether it's the euphoria produced by drugs like fentanyl and methamphetamine or the relief of withdrawal symptoms that virtually any drug produces for individuals who are dependent on it. Conditions like sickle cell anemia or chronic pain include no comparable rewards. Second, in conditions like sickle cell anemia and chronic pain most (not all, but most) of the suffering falls on the person who has it, whereas in addiction the balance of costs is often reversed, with for example families, friends, and the community suffering more than is the person who is addicted. Because their condition includes no rewards and imposes great costs on them personally, people with conditions like sickle anemia and chronic pain are usually high motivated to seek treatment. But facing a different balance of costs and benefits, addicted people usually do not seek treatment and recovery without external pressure from family, friends, employers, health care providers, or the law.

This matters because Oregon has removed all legal pressure to stop drug use and seek treatment. Because many addicted individuals are not working or in touch with family, those pressures to stop using drugs and alcohol are also often absent in their lives. Because the West Coast has an

individualistic culture with significant tolerance for substance use, social pressures to seek treatment are often minimal as well. So, on the one hand, we have highly rewarding drugs which are widely available, and on the other hand little or no pressure to stop using them. Under these conditions, we should expect to see exactly what Oregon is experiencing: Extensive drug use, extensive addiction and not much treatment seeking.

It's worth noting that Portugal, which is often cited as the inspiration for Oregon's drug policy, places heavy social and legal pressure on addicted people to seek treatment. The open use and flagrant drug dealing in West Coast cities are virtually absent in Portugal, which shuts them down and uses court pressure to get people into treatment. I have spent a lot of time in Portugal and know the people who designed their policy, so please take it from me: Oregon is not following Portugal's example and will not get its results.

Point 2: Evidence-based harm reduction can save lives, but it can't do it alone. Making the opioid overdose rescue drug naloxone more available, for example, translates into a smaller proportion of overdoses resulting in death or permanent disability. But harm reduction is not harm elimination - people who use drugs will still suffer. Pease combine in your mind this reality with another important fact: Reducing the harm of drug use will never reduce the size of the addicted population – that is the role of addiction treatment and recovery support in the short term and prevention in the long term. If no is ever prevented from becoming addicted and no one who is addicted ever gets into recovery, the harm from drug use will rise no matter how much harm reduction is available because the size of the population using drugs keeps growing and we can never make drug use completely free of harm.

A further limitation of harm reduction as typically conceived and implemented on the West Coast (again a big contrast with European countries like Portugal) is that it tends to focus exclusively on the individual who uses drugs, rather than also trying to reduce harm to the community as whole. Harm reduction for people who use drugs does not necessarily translate into harm reduction for everyone

else. For example, a person using methamphetamine who is suffering from meth-induced psychosis and has become violent to his family can be given clean syringes to help avoid infectious disease, but this does nothing to reduce the violence the user's family is experiencing. Current harm reduction policy doesn't take this reality seriously enough. A prominent example of this blind spot in many West Coast cities is tolerance of the open-air drug markets that make neighborhoods a terrible place to raise a family no matter how much drug user-focused harm reduction policies are put into place.

If Oregon continues on its current path of not complementing effective harm reduction with strong prevention and treatment initiatives, and of focusing harm reduction only on people who use drugs, it should expect rising drug use, addiction, and harms to communities. If the people of Oregon conclude that those costs are bearable, then of course they have a right to that decision in our democracy. But recent elections in places like San Francisco and Seattle suggest to me at least that there is a limit to how much community harm from drug use voters will tolerate in the long term. That means we need treatment and prevention policies that actually reduce drug use, as well as harm reduction programs that recognize the need to protect communities from the harms of drug use.

Point 3: A possible alternative approach to the current policy is to engage law enforcement to close down open-air drug markets and end their community harms, while simultaneously supporting the health community to expand treatment and recovery support. This policy shift would also use legal pressure on persons who become addicted and get arrested for something other than drug possession per se, such as car theft, catalytic converter theft, robbery, assault, or vandalism. Swift, certain, and fair models of community supervision can be used to reduce substance use with or without treatment, following the example of neighboring states. This leaves drug possession for personal use itself decriminalized – consistent with the will of Oregon voters - but applies pressure to stop drug use in those cases where a drug-using individual commits crimes that threaten public safety.

To summarize my three points:

1 People who are addicted are less likely to seek treatment than are individuals with other chronic illnesses whose costs fall mainly on the person who suffers from them, so if there is no formal or informal pressure on addicted people to seek treatment and recovery and thereby stop using drugs, we should expect continuing high rates of drug use, addiction and attendant harm.

2 Evidence-based harm reduction improves public health, but a policy solely focused on harm reduction for people who use drugs will over time result in increased harm both to people who use drugs and people who do not. It must be accompanied by policies that shrink the size of the addicted population and reduce community harms.

3 There are multiple opportunities to use an alliance of smart policing, low-threshold health services, and swift, certain, and fair community corrections to significantly reduce the damage that addiction is currently inflicting in Oregon.

Thank you for your time. I look forward to your questions.